BABY DAWN: Bed-Sharing with Infants in Foster Care

An Investigative Review

JULY 2014

Under my authority and duty as set out in the *Child and Youth Advocate Act*, I am providing the following Investigative Review concerning the death of a six-week-old infant who was, at the time, receiving services from the Government of Alberta. Consistent with section 15 of the Act, the purpose of this report is to learn from this tragic event and recommend ways of improving Alberta's child intervention system.

While this is a public report, it contains detailed information about children and families. My office has taken great care to protect the privacy of the family members of the infant involved. The names used in this report are pseudonyms and the report refrains from disclosing information that could be used to identify the infant or her family.

Accordingly, I would request that readers and interested parties, including the media, respect this privacy and not focus on identifying the individuals and locations involved in this matter.

This Investigative Review is about an infant who died when she was just 45 days old. She had been in a foster home for 24 days. Her foster parents had cared for approximately 30 foster children over 10 years. They were well trained and well supported by foster care and child intervention staff. They knew about safe sleeping practices with infants.

Yet, she was found unresponsive in her foster parents' bed, and she died. The Office of the Chief Medical Examiner determined she died as a result of undetermined causes when she was bed-sharing with adults. There was nothing in any of the information we reviewed to indicate any harm was intended.

If there is one message I can convey to those who open their homes and share their family with children through fostering, it is this – Please do not sleep while sharing a bed with a vulnerable infant in your care. The potential consequences of sharing a bed with an infant can be catastrophic. This is a message about keeping infants in foster care safe.

This infant will be remembered as a beautiful and contented baby girl. Her loss is a tragedy for her family and others who cared for her. Our thoughts and sincere condolences are extended to those who knew her.

[Original signed by Del Graff]

Del Graff
Child and Youth Advocate

ocya OFFICE OF THE CHILD AND YOUTH ADVOCATE ALBERTA

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EXECUTIVE SUMMARY

Alberta's Office of the Child and Youth Advocate (the "OCYA") is an independent office reporting directly to the Legislature of Alberta, deriving its authority from the *Child and Youth Advocate Act*. One role of the Child and Youth Advocate (the "Advocate") is to "investigate systemic issues arising from a serious injury to or the death of a child who was receiving a designated service at the time of the injury or death if, in the opinion of the Advocate, the investigation is warranted or in the public interest."

In 2013, six-week-old Dawn (not her real name)[1] was found unresponsive in her foster parents' bed. She was transported to hospital where she was pronounced dead. The Office of the Chief Medical Examiner found the cause of death to be undetermined. At the time of her death, Dawn was the subject of an Interim Custody Order.

Dawn had six older half-siblings, two of whom were in foster care at the time of her birth due to concerns regarding possible risk of abuse. Based on this, Child Intervention Services became involved with Dawn when she was discharged from hospital into the care of her parents. When she was three weeks old, she was apprehended and placed in a foster home. Her maternal aunt was identified as a possible kinship caregiver three days after Dawn was apprehended and background checks on her aunt commenced.

Dawn's foster parents, Mike and Carrie Smith, were experienced caregivers. They had been licensed as a foster home for approximately 10 years and over this time approximately 30 children were placed in their home. At the time of Dawn's placement, two other children (ages 12 and one year old) had already been placed in the Smith foster home for a year. The Smiths also had two biological children (ages 10 and 8 years old) living in their home. In addition, the Smiths provided respite care on occasion to four children from another foster home (ranging in ages from 8 to 16 years old). All of the children were in the home when Dawn passed away.

Sometime through the night, Carrie brought Dawn into the foster parents' bed. Recollections of the timing and events of the night are varied. But, at approximately 5:00 a.m. Dawn was found not breathing and unresponsive in the foster parents' bed. She was transported by ambulance to the hospital where she was pronounced dead. At the time of her death, Dawn was 45 days old and had been in the Smiths' foster home for 24 days.

1 All names used throughout this Investigative Review are pseudonyms. Section 15(3) of the *Child and Youth Advocate Act* states that a report must not disclose the name of, or any identifying information about, the child to whom the investigation relates or a parent or guardian of the child.

This Investigative Review examined three potential systemic issues:

- The total number of children in the care of a foster parent
- Placing a child in a home with a prospective kinship care provider
- Safe sleep practices with infants

This Investigative Review found:

- At the time of Dawn's passing, the Smiths were caring for nine children, which included four children for whom the Smiths were providing respite care. The Ministry of Human Services has policies and procedures to ensure that foster families providing respite are able to adequately care for and supervise the children placed in their home. In this case, the policies and procedures were adhered to. This was an arrangement that had been in place for almost 10 years.
- The policy and procedures for the recruitment and approval of kinship care homes were followed appropriately. Although Dawn's maternal aunt was a potential kinship care placement, Dawn could not be placed with her until formal child intervention and criminal record checks were completed. In the meantime, Dawn was placed in a foster home with experienced caregivers.
- Based on information provided by the Office of the Chief Medical Examiner regarding child deaths as a result of bed-sharing, supported by the Public Health Agency of Canada, the Ministry of Human Services has taken steps to ensure the dangers of bed-sharing[2] are shared with caseworkers and foster parents. However, current policies do not specify that foster parents should not bed-share with infants placed in their care.

The Advocate is making one recommendation:

Recommendation 1:

The Ministry of Human Services should implement clear policy for foster parents providing direction not to bed-share with infants placed in their care.

2 The Canadian Paediatric Society (Leduc, Côté, Woods & the Community Paediatrics Committee, 2004) refers to bed-sharing as a sleeping arrangement in which the baby shares the same sleeping surface with another person. Co-sleeping refers to a sleeping arrangement in which an infant is within arm's reach of his or her mother, but not on the same sleeping surface.

INTRODUCTION

The Office of the Child and Youth Advocate

Alberta's Office of the Child and Youth Advocate (the "OCYA") is an independent office reporting directly to the Legislature of Alberta. The Child and Youth Advocate (the "Advocate") derives its authority from the *Child and Youth Advocate Act*,[3] which came into force on April 1, 2012.

The role of the Advocate is to represent the rights, interests and viewpoints of children receiving services through the *Child, Youth and Family Enhancement Act* (the Enhancement Act),[4] the *Protection of Sexually Exploited Children Act*[5] (PSECA), or from the Youth Criminal Justice System.

Investigative Reviews

Section 9(2)(d) of the *Child and Youth Advocate Act* provides the Advocate with the authority to conduct investigative reviews and states, "The Advocate may investigate systemic issues arising from a serious injury to or the death of a child who was receiving a designated service at the time of the injury or death if, in the opinion of the Advocate, the investigation is warranted or in the public interest."

Through the Investigative Review process, the services provided to the young person are examined; and, findings and recommendations are identified to help make systemic changes that will lead to better outcomes for children and youth throughout the province. The final report is non-identifying and made public.[6]

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3 *Child and Youth Advocate Act*, S.A. 2011, c. C-11.5.

4 *Child, Youth and Family Enhancement Act*, RSA 2000, c. C-12.

5 *Protection of Sexually Exploited Children Act*, RSA, c. P-30.3.

6 Following legislative changes made by the *Child, Youth and Family Enhancement Amendment Act*, 2014 ("Amendment Act") the publication ban will be lifted in respect of a deceased child such that the name or a photograph of a deceased child or his/her parent or guardian may be published in a manner that reveals that the child has received intervention services. At the time this review was concluded, the section of the Amendment Act lifting the publication ban in respect of a deceased child was not yet proclaimed into force. However, the legislative changes do not alter the requirement under the *Child and Youth Advocate Act* for the Advocate to release a non-identifying public report.

An Investigative Review does not assign legal responsibilities nor does it supplant or abrogate other processes that may occur, such as investigations or prosecutions under the *Criminal Code of Canada*. The intent of an Investigative Review is not to find fault with specific individuals, but to identify key issues along with meaningful recommendations which:

- are prepared in such a way that they address systemic issue(s); and,
- specific enough that progress made on recommendations can be evaluated; yet,
- not so prescriptive to direct the practice of Alberta government ministries.

It is expected that ministries will take careful consideration of any recommendations, and plan and manage their implementation along with existing service responsibilities. The Advocate provides an external review and advocates for system improvements that will help enhance the overall safety and well-being of children who are receiving designated services. Fundamentally, an Investigative Review is about learning lessons, rather than assigning blame.

ABOUT THIS REVIEW

In 2013, the Child and Youth Advocate received a report of death regarding six-week-old Dawn. Her foster parents, Mike and Carrie, found her unresponsive in their bed at approximately 5:00 a.m. Dawn was transported to hospital where she was pronounced dead. The Office of the Chief Medical Examiner (OCME) found the cause of death to be undetermined.[7] At the time of her death, Dawn was the subject of an Interim Custody Order.[8]

The Child and Youth Advocate thoroughly reviewed file information provided by Child Intervention Services and the police service. A preliminary report was completed which identified potential systemic issues warranting an Investigative Review. The Advocate subsequently advised the Minister of Human Services that a review into the circumstances of Dawn's death would be conducted.

Terms of Reference for the Investigative Review were established, a copy of which is provided in Appendix 1. A team was assigned to gather information and conduct an analysis of Dawn's circumstances through a review of relevant documentation, interviews and research. A number of individuals were identified who could provide insight into Dawn's circumstances.

Dawn's parents were contacted and met with the Investigative Review team. They shared their experience freely and wanted Dawn's story shared.

A committee of subject matter experts was not convened in this case. It was determined that resources should be directed toward the education of foster parents about the risks of bed-sharing with infants placed in their care. The Child and Youth Advocate is hopeful that every foster parent in Alberta be aware of this report and its recommendation.

7. In Alberta, "undetermined" cause of death now encompasses those deaths previously classified as Sudden Infant Death Syndrome (SIDS).

8. When a child is brought into care under an Apprehension Order an application for Initial Custody must be filed within 10 days providing the rationale why the child should remain in care. In this case the Initial Custody hearing was adjourned and an Interim Custody Order was granted.

BACKGROUND

About Dawn

Dawn appeared to be a healthy newborn infant and weighed 7 lbs. 15 oz. (3600 grams) at birth. Her parents described her as a very healthy and contented baby.

About Dawn's Family

Dawn had six older half-siblings. A copy of Dawn's genogram can be found in Appendix 2.

Dawn's mother, Kate, is of First Nations heritage and her father, Peter, is Caucasian. Kate and Peter were both involved with the child intervention system as children, and later again as parents. At the time of Dawn's birth, two of her half-siblings were in the care of the Ministry of Human Services due to concerns regarding possible risk of abuse.[1]

1 Details regarding the family's current and historical child intervention details are not provided as this review focuses on systemic issues related to placement outside of the parental home.

Dawn in Parental Care

Shortly after Dawn's birth, a concern was raised when Kate informed medical staff that two of her children were in foster care. Dawn was discharged from the hospital into the care of her parents. Her family was supported by family members and a community-based agency.

One week later, an assessor[10] completed a home visit with the family. During this visit, Dawn appeared to be in good health. Peter shared the results of a recent psychological assessment that he had arranged. The assessor and caseworker were concerned that Peter minimized his behaviours. This along with the family's history contributed to a decision to apply for an Apprehension Order.[11] It was determined that the potential risk of abuse to three-week-old Dawn required placement outside of parental care.

Dawn was placed in Carrie and Mike Smith's foster home. Three days after she was apprehended, Dawn's maternal aunt was identified as a possible kinship caregiver[12]. Formal background checks of Dawn's maternal aunt were undertaken.

About Dawn's Foster Family

The Smiths were experienced caregivers who mentored and trained new foster parents. They had been licensed as a foster home for about 10 years and approximately 30 children had been placed in their home. The majority of foster children placed in the Smiths' home were in their mid to late teens.

At the time of Dawn's placement there were two foster children, Douglas (12 years old) and Stephen (1 year old), in the Smiths' home. They had been in the home for approximately one year. In addition to Douglas and Stephen, the Smiths' two biological children, ages 10 and 8 years old, also lived in the home. The Smith home was licensed for four children. Birth children and children in the home for short term respite are not counted in the four approved placements. A genogram of the Smith foster home is provided in Appendix 3.

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10 Assessor – This is a child intervention worker who responds to reports of concern by making initial contact with the family and gathering information.

11 Apprehension Order – An Apprehension Order is sought when a child cannot be adequately protected in their family setting. The court grants the Director temporary custody and guardianship of the child. Guardianship is shared with child's parent/legal guardian. The child is placed in an approved placement.

12 Relatives or members from a child's community who are approved by Child Intervention Services to provide in-home care for a child.

The Smiths also provided respite care[13] on occasion, for a few days at a time, for four children from another foster home, who ranged in age from 8 to 16 years old. This was a long-standing arrangement, of almost 10 years, that involved the approval of their caseworker and the Smith's foster care worker. These children were in the home when Dawn passed away.

After Dawn's placement, a previous foster child made an allegation about emotional abuse in the Smith foster home. This allegation was investigated[14] and found to be unsubstantiated.[15]

Dawn in Foster Care

Dawn was 21 days old when she was placed in Carrie and Mike Smith's home. Carrie expressed concerns about Dawn's overall health. She appeared to be underweight and had vascular redness in the whites of her eyes. During the 24 days that Dawn was in the foster home, Carrie took her to a physician six times. Dawn was gaining weight, so the frequency of medical appointments (for the purpose of monitoring weight gain) was decreased.

Dawn had regular supervised visits with her parents while she was in the foster home.

Dawn's Final Days

The day before Dawn passed away, a physician diagnosed her with thrush.[16] She was prescribed oral antibiotics and cream to treat a diaper rash.

The Smiths were providing respite to the four children whom they often cared for, for a few days. They attended one of the children's sporting events in the evening and watched movies. At midnight, Carrie fed Dawn a bottle and placed her in a crib playpen[17] beside the foster parents' bed.

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13 Respite care is to provide foster parents with a break from the complex behavioural or medical needs of a child in their care. Respite must be provided out of the foster parent's home by licensed foster parents. Respite foster parents must have the level of skill, knowledge and ability to meet the needs of the child. Respite children are not counted in the approved number of placements as they are only in the foster home for a short period of time.

14 Also referred to as an "Assessment" in more recent years, this is the initial contact that Child Intervention Services has with a family after they have received concerns that a child may be at risk.

15 "Unsubstantiated": after an investigation of a report of child abuse or neglect, it is determined that insufficient evidence exists to fully determine whether child abuse or neglect occurred.

16 Thrush is a very common infection in infants that causes irritation in and around a baby's mouth. It is caused by the overgrowth of the yeast (a type of fungus) called *Candida albicans*. Candida overgrowth can lead to diaper rashes, or oral thrush in infants.

17 Crib playpen is a playpen with a removable bassinet. The bassinet accommodates infants from birth to 15 pounds, up to 25". This can be used until four months of age. A picture is provided in Appendix 4.

Sometime through the night Carrie brought Dawn into the foster parents' bed. Recollections of the timing and events of the night are varied. But, at approximately 5:00 a.m. Dawn was found not breathing and unresponsive in the foster parents' bed. Carrie and Mike immediately started cardiopulmonary resuscitation and called emergency services. Dawn was transported by ambulance to the hospital where she was pronounced deceased.

Child Intervention staff notified Dawn's parents in person and supported them at the hospital. To align with cultural practice, a casting of Dawn's feet and hands was completed and provided to her parents. Additional supports, including counselling, were offered to the family.

The Office of the Chief Medical Examiner ("OCME") conducted a re-enactment to help provide information about the circumstances of Dawn's death. The OCME determined she died as a result of undetermined causes when she was bed-sharing[18] with adults.

The police determined that Dawn's death was non-criminal and closed their investigation.

The Placement Resource Assessment Team[19] (PRAT) completed an investigation on the Smith foster home. The investigation involved interviews with the foster children, the police, the OCME, the foster care worker and the foster parents. Bed-sharing was not a normal practice in the Smith home. The investigation was closed as unsubstantiated.

After Dawn's death the Smiths agreed not to provide respite care for other foster families and their foster care license would be limited to their current two placements (Douglas and Stephen) for a period of six months. At the conclusion of that time their situation would be re-evaluated. Trauma/grief therapy was provided to all members of the family.

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18 The Canadian Paediatric Society (Leduc, Côté, Woods & the Community Paediatrics Committee, 2004) refers to bed-sharing as a sleeping arrangement in which the baby shares the same sleeping surface with another person. Co-sleeping refers to a sleeping arrangement in which an infant is within arm's reach of his or her mother, but not on the same sleeping surface.

19 The Placement Resource Assessment Team is a unit of specialized assessors who investigate concerns in placement resources for children in care.

DISCUSSION

The purpose of an Investigative Review is to identify systemic issues, findings and recommendations to help make systemic changes that will lead to better outcomes for children and youth throughout the province.

As identified in the Terms of Reference, three potential systemic issues were reviewed:

1. The total number of children in the care of a foster parent;
2. Placing a child in a home with a prospective kinship care provider; and,
3. Safe sleep practices with infants.

The total number of children in the care of a foster parent

At the time of Dawn's death, the Smiths had nine children in their home. This included their two biological children; three foster children; and four children from another foster home for whom they were providing respite care. The latter four children were in the Smiths' care for a few days. All of the children, except for Stephen and Dawn, were over eight years old.

The Smiths had provided ongoing respite care for the four children for a number of years and no issues had been identified about their care. The respite was a formal arrangement approved by the foster care worker and the respite children's caseworker.

The Smith home was licensed for four foster children. The children in the home for short term respite and birth children are not included in the approved placement numbers. The maximum number of children in the home did not exceed policy.

The Ministry has policies and procedures to ensure that foster families providing respite are able to adequately care for and supervise the children placed in their home. In this case, the policies and procedures were followed.

Placing a child with a prospective kinship care provider

Dawn's maternal aunt was willing to care for her. The rationale for not placing Dawn in her aunt's home was documented. Formal child intervention and criminal record checks had to be completed prior to placing Dawn with her aunt. This would allow time to sort out Dawn's medical concerns and to ensure appropriate supports were in place to support her caregivers.

Policy and procedures for the recruitment and approval of kinship care homes is an existing process to ensure child safety. It appears that they were followed appropriately.

Safe sleep practices with infants

Safe sleep practices reduce the risk of Sudden Infant Death Syndrome (SIDS).[20] However, there are confusing messages for parents. Public health agencies promote that infants should always sleep in a crib to reduce the risk of SIDS; infants should never sleep in bed with adults (bed-share). At the same time there is a current stream of thought about the importance of "attachment parenting."[21] And, traditional Indigenous (specifically Cree) practice also identifies bed-sharing to promote more positive

20 In Alberta, "undetermined" cause of death now encompasses those deaths previously classified as Sudden Infant Death Syndrome (SIDS).

21 Attachment parenting promotes bed-sharing and skin-to-skin contact to enhance bonding between the parent and infant.

attachment and sleep for both the infant and mother.[22] Parents must make an informed decision, taking into consideration all the risk factors along with their cultural practices, ease of breastfeeding, attachment and safety.

Quoted from the National Post, "Doctors warn against co-sleeping, but a growing number of parents willing to take risk to feel close to their child,"[23] Dr. Weiss, Director of the Sleep/Neurology Clinic at Toronto's Hospital for Sick Children states:

> *"The problem is that if we say 'OK you can co-sleep with these conditions – firm mattress, no blankets, no pillows' – it's very hard to be prescriptive of how co-sleeping may be entirely safe. It's kind of a slippery slope that people might think 'Well, I don't drink, I don't smoke, I don't do drugs. I have a good mattress' but maybe they forget that their blanket's too heavy," she said. 'There's too many factors, whereas if you put a baby in a crib with a mattress that's been certified ... without pillow and bumpers and on their back, we know that's safe."*

In 2011, the OCME presented statistical information to the Pediatric Death Review Committee[24] on child deaths as a result of bed-sharing. The information was supported by the Public Health Agency of Canada which advised that bed-sharing had been identified as a risk factor for undetermined death in infants and could also lead to suffocation.

Representatives from the Ministry of Human Services brought this information forward as a concern for children in foster care. The Director of the *Child, Youth and Family Enhancement Act* provided information to all Child Intervention Services areas to ensure that the dangers of bed-sharing would be shared and discussed with caseworkers and caregivers.[25] A booklet and pamphlet regarding safe sleep practices was provided to all service areas to share with caregivers.

On September 6, 2013, information was sent to all of the Directors of Delegated First Nations Agencies, Chief Executive Officers of Child and Family Services Authorities and other representatives from Child Intervention Services from the Policy, Practice and Program Development, Child and Family Services Division of Human Services. The information was sent to ensure that caregivers would be made aware of safe sleep practices for infants which included putting the baby on his/her back to sleep and using a crib that meets government safety standards. Safe sleeping practices for infants are to be discussed with foster parents annually when completing the Environmental Safety Assessment Checklist for Caregivers.

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22 Pazderka, et al., 2014.

23 Boesveld, 2014.

24 The Pediatric Death Review Committee was a multidisciplinary group convened to discuss child deaths in northern Alberta (i.e., from Red Deer to the north). It is no longer in existence.

25 Memo from the Director of *Child, Youth and Family Enhancement Act*, November 23, 2011.

On December 1, 2013, links were added to the *Child, Youth and Family Enhancement Policy Manual*, section 3.2.7 Environmental Safety, to include Alberta Health Services' "Safe Sleep Resources" and the Public Health Agency of Canada's "Safe Sleep" website. Links were also added to section 7.3.2 Placing a Child, for Health Canada's "Is Your Child Safe?" booklet series, as well as the Public Health Agency of Canada's "Safe Sleep for Your Baby" brochure.

The Environmental Safety (Section 3.2.7) policy regarding "Sleeping Arrangements" states:

- *Inform the foster parents that each foster child must have a separate bed or crib as a permanent sleeping arrangement, based on the age and development of the child, which meets Canadian safety standards.*
- *No child under the age of six years can sleep on the top bunk of a bunk bed.*
- *Alberta Health Services safe sleep practices for infants must be followed, including putting baby on back to sleep and keeping the baby warm, not hot.*
- *Cribs must be free of quilts, comforters, bumper pads, stuffed animals, pillows and other pillow-like items.*

Human Services has a two-day training course for foster parents entitled, "Safe Babies Caregiver Education Program" which is intended for caregivers of infants prenatally affected by substance use. Module 5 includes, "Safe Sleep Practices Reduce SIDS". In this section there is a statement, "do not share the bed" and discussion about safe sleep practices. The course is not mandatory for foster parents caring for infants. However, the Ministry has advised that a new "Safe Babies" training is being implemented in the fall of 2014 which will be required for all foster parents caring for infants.

Foster care workers and child intervention caseworkers are left to provide the information on safe sleep practices to foster parents. Their tools are website links and brochures on safe sleep developed by Alberta Health and the Public Health Agency of Canada. While information from both agencies do not recommend bed-sharing and identifies the dangers, no statement is made regarding infants in foster care. Current child intervention policy does not provide clear direction that foster parents should not bed-share with the infants placed in their care. Foster parents are taking on the responsibility of providing care to someone else's child and the decision about bed-sharing should not be the foster parents'.

Recommendation 1:

The Ministry of Human Services should implement clear policy for foster parents providing direction not to bed-share with infants placed in their care.

CLOSING REMARKS FROM THE ADVOCATE

The Child and Youth Advocate wishes to thank and acknowledge all of the individuals who contributed to this Investigative Review.

This Review found that policy and procedures regarding the number of children in the care of a foster parent and placing a child with a prospective kinship care provider were followed.

Regarding safe sleep practices with infants, there are conflicting theories about what is best for babies. Some argue that "attachment parenting" which includes bed-sharing is best; while public health agencies and medical professionals recommend that babies should sleep in a crib. But, at the end of the day when children are in the care of the the Ministry of Human Services everything that can be done to make them safe needs to be done.

Foster parents are very special people who take the most vulnerable children into their care, wanting to help children and families reach their potential. They need to be provided with all the supports they need to ensure the safety and well-being of the young people they care for. It is critically important that foster parents are provided with sound information about safe sleeping practices, a clear message about the potential danger of bed-sharing with infants, and policy that provides direction for foster parents not to bed-share with infants.

I want all foster parents in Alberta to be aware of this Investigative Review and recommendation with the hope that the dangers of bed-sharing with infants will be recognized. Baby Dawn's death is a tragedy. Hopefully, her story will result in positive change regarding foster parents bed-sharing with infants.

[Original signed by Del Graff]

Del Graff
Child and Youth Advocate

APPENDIX 1: TERMS OF REFERENCE

Incident

In 2013, six-week-old Dawn was found unresponsive in her foster parents' bed. She was transported to hospital where she was pronounced dead. Results from the Office of the Chief Medical Examiner are still pending (later the cause of death was found to be "undetermined").

At the time of her death, Dawn was the subject of an Interim Custody Order[26] pending an Initial Custody hearing.[27]

Authority

Alberta's Office of the Child and Youth Advocate is an independent office reporting directly to the Legislature of Alberta. The Child and Youth Advocate derives his authority from the *Child and Youth Advocate Act*. The role of the Advocate is to represent the rights, interests and viewpoints of children receiving services through the *Child, Youth and Family Enhancement Act*, the *Protection of Sexually Exploited Children Act* or from the Youth Criminal Justice System.

Section 9(2)(d) of the *Child and Youth Advocate Act* provides the Advocate with the authority to "investigate systemic issues arising from a serious injury to or the death of a child who was receiving a designated service at the time of the injury or death if, in the opinion of the Advocate, the investigation is warranted or in the public interest".

The Child and Youth Advocate received a report of death regarding Dawn. The decision to conduct an investigation was made by Del Graff, Child and Youth Advocate.

Objectives of the Investigative review

1. To review and examine the supports and services provided to Dawn specifically related to:

- The total number of children permitted to be under the care of a foster parent
  - The foster home was within the allowed number of child placements according to policy, yet there were a total of 9 children in home at the time that Dawn passed away. How do we consider the number and needs of children that foster parents may be providing babysitting or respite care for?

26 An Interim Custody Order gives authority for the Director to maintain a child in their care pending the outcome of a trial or hearing.

27 An Initial Custody Hearing allows the guardians the opportunity to challenge in court the reasons why a child was apprehended.

28 A Foster Home with a Level 2 classification can have up to a maximum of four foster children placed in it. Birth children and respite children are not counted in the maximum number of placements.

- Does policy need to specifically address the impact of respite or babysitting on the capacity of caregivers?

- Safe sleep practices with infants
  - Despite an increased emphasis in recent years to educate caregivers about safe sleep practices with infants, Dawn's foster parent decided to co-sleep with her the morning she passed away. It needs to be determined if the foster parent had been made aware of safe sleep practices. If this was the case, were there other factors that impaired their decision?
  - Is policy sufficiently clear and specific enough to address co-sleeping?

- Placing a child in a home with a prospective Kinship Care provider.[29]
  - Dawn had the opportunity to be placed with her maternal aunt and uncle yet moving her there was postponed until all the formal record checks were completed. It was reasoned that Dawn's immediate needs were being met in foster care so there was no urgency to place her. Clarification is needed to understand when placement with a prospective Kinship Care provider may or may not be the best decision for a child.

2. To comment upon relevant protocols, policies and procedures, standards and legislation.
3. To prepare and submit a report which includes findings and recommendations arising from the investigative review.

Scope/Limitations:

An Investigative Review does not assign legal responsibilities, nor does it supplant or abrogate other processes that may occur, such as investigations or prosecutions under the *Criminal Code of Canada*. The intent of an Investigative Review is not to find fault with specific individuals, but to identify and advocate for system improvements that will enhance the overall safety and well-being of children who are receiving designated services.

Methodology:

The investigative process will include:

- Examination of critical issues;
- Review of documentation and reports;
- Review of Enhancement Act Policy and casework practice;

29 Section 2.1.3 of the Enhancement Policy Manual outlines the requirements needed to place a child with a prospective Kinship Care Provider prior to formal completion of the criminal record checks.

- Review of case history;
- Personal Interviews:
  - Child and Family Services Authority (CFSA) staff
  - Medical service providers
  - Foster care staff
- Consultation with experts as required; and
- Other factors that may arise for consideration during the investigation process.

Investigative Team

Lead investigator: Office of the Child and Youth Advocate

Secondary investigator: To be determined

Investigative Review committee[30]

The membership of the committee will be determined by the Director and the Advocate. The purpose of convening this committee is to review the preliminary investigative review report and to provide advice regarding findings and recommendations.

Chair: Del Graff, Child and Youth Advocate

Members: To be determined but may include:

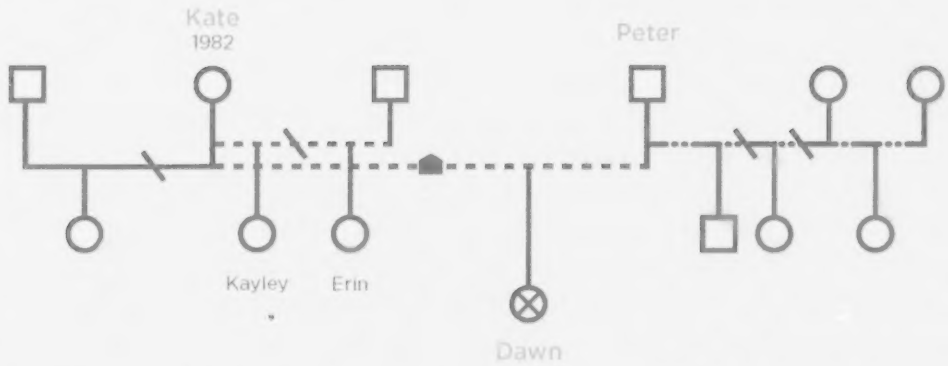
- A pediatrician
- A specialist in the area of foster care delivery
- A researcher who has collected and analyzed data with respect to infant co-sleeping

Reporting Requirement

The Child and Youth Advocate will release a report when the Investigative Review has been completed.

30 A committee was not convened at the conclusion of the review as it was determined that resources should be directed at educating foster parents.

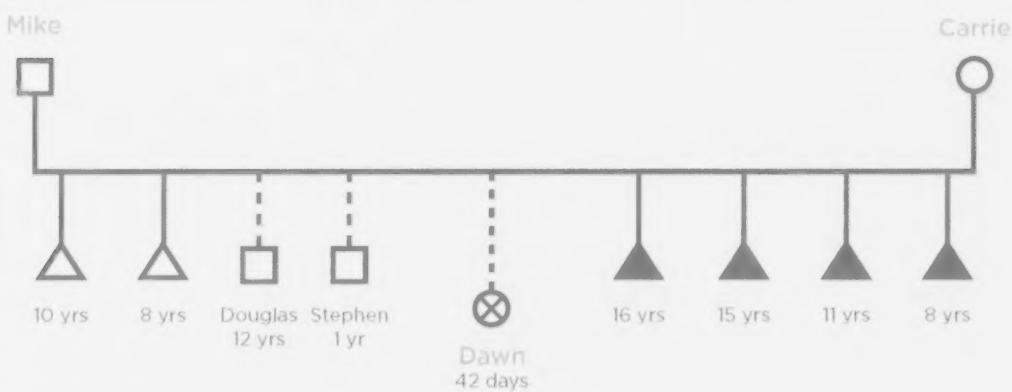
APPENDIX 2: DAWN'S GENOGRAM



Legend

Male Female Death Separation in fact Legal cohabitation & separation in fact Legal cohabitation Cohabitation & separation

APPENDIX 3: SMITH FOSTER HOME GENOGRAM



Legend

Male Female Death Biological children Visiting children Foster children

APPENDIX 4

Picture of a crib-playpen similar to Dawn's.

APPENDIX 5: REFERENCES

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